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ABSTRACT

This study compares the attitudes of two groups of professionals involved in adolescent drug and alcohol treatment regarding the usefulness of Mediated Learning Experience as a supplement to Multi Systemic Treatment (MST) for substance abuse. Fifteen social workers and 15 school psychologists completed a rating scale to record their opinions of MST, to assess their reactions to several areas of therapy, and to answer questions about parents and teachers as part of the therapy process. The survey found a favorable attitude toward considering this inclusion, as well as no difference between the attitudes of the two groups. Limitations were noted on the size of the groups and the method used to obtain respondents. Respondents voiced a positive attitude regarding the addition of MLE to their treatment plans. The useful role of the school psychologist was demonstrated regarding their ability to contribute to data-based decision making. (Contains 20 references.) (JDM)

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ATTITUDES OF MENTAL HEALTH WORKERS AND PSYCHOLOGISTS REGARDING THE USEFULNESS OF MEDIATED LEARNING EXPERIENCE AS A SUPPLEMENT TO MULTI SYSTEMIC TREATMENT

By

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Thesis

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Abstract

This study compares the attitudes of two groups of professionals involved in adolescent drug and alcohol treatment regarding the usefulness of Mediated Learning Experience (MLE) as a supplement to Multi Systemic Treatment (MST) for substance abuse. Fifteen social workers and fifteen school psychologists completed a rating scale to register their opinions. The results showed that both groups responded favorably. There was no difference in the expressed attitudes of the respondents from either group.

Introduction

Research has shown that substance abuse among adolescents shares comorbidity with other mental illnesses (Clark & Buckman, 1998). There has been considerable work to develop treatment plans for adolescent substance abuse; however, these programs must treat both substance abuse and the associated pathologies that are included in substance abuse.

The most common psychopathologies that coexist with alcohol and substance abuse are negative affect disorders such as depression and problems that interface with social functioning such as antisocial disorders (Buckstein et al., 1989). Substance abuse development in adolescence may also be an important indicator of other problems. For example, Clark and associates (1998) found that male adults with substance abuse disorder that developed in adolescence were more likely to display disruptive behaviors. The rapidity of transfer from one substance use to another substance abuse was also greater among adult drug abusers who started in adolescence.

Theories that attempt to explain the development of alcohol and substance abuse in adolescents typically state that the associated psychopathology increases the probability of substance abuse (Zucker, 1987). Once alcohol and substance abuse start, the risk of further development of psychopathologies also tends to increase (Martin & Bates, 1998).

The complex nature of substance abuse and its associated pathologies continues to challenge all attempts at treatments. To date, prevailing approaches rely heavily on

varieties of behavioral models. Yet the treatment outcomes remain disappointingly low, as gains made during the course of treatment often fail to generalize to other life experiences. Alternatives such as more cognitively based approaches offer promise of improved generalizability for substance abusers. This paper compares the prevailing behavioral approach with an alternative cognitive approach to treatment of substance abuse, and reports the results of a needs assessment among professionals currently employing a popular behavioral treatment regarding their openness to consideration of a promising cognitive model.

Review of literature

The most common pathologies that share a diagnosis with alcohol and substance abuse are antisocial disorders and negative affect disorders. The antisocial disorders include conduct disorders, oppositional defiant disorder (ODD) and antisocial personality disorder. The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) (APA, 1994) defines conduct disorder, the most common disorder associated with adolescents with alcohol abuse, as patterns of behavior that violate the rights of others, or break major age appropriate social rules. Behaviors that may indicate conduct disorders are divided into four categories (1) aggression to people and animals (2) destruction of property (3) deceitfulness or theft and (4) serious violations of rules.

Conduct disorder is often preceded by the development of ODD (Loeber et al., 1993). In DSM-IV the diagnostic criteria for ODD encompass less severe criteria than conduct disorder. These criteria include lying, loss of temper, blaming others for ones own behaviors, and inappropriate anger.

Conduct disorder often predates and predicts alcohol use (Lynskey & Fergussen, 1995). Reasons for this relationship include the tendency of adolescents with conduct disorder to display novelty-seeking behavior. This can result in drinking at an early age. Another reason given for the relationship between conduct disorder and alcohol abuse is the poor behavioral inhibition typically displayed by adolescents with conduct disorder (Lewis & Bucholz, 1991).

Another theory known as problem behavior theory suggests that these disorders share common risk factors (Clark & Buckstein, 1998). These include family, socioeconomic, and parenting factors, as well as individual problems that increase the adolescent's vulnerability to these problems. According to this theory, alcohol and other substance abuse are seen as among a number of behaviors resulting from common risk factors. It is important to note that the main difference between these theories is whether the adolescent is viewed as an individual or as part of a system. This difference has implications in both diagnosis and intervention.

Negative affect disorders include those that cause mood disturbances and depression and those that increase anxiety. The negative affect disorders that commonly coexist with alcohol and substance abuse disorder are major depression and posttraumatic stress disorder (PTSD). For adolescents, the DSM-IV criteria for major depression include depressed mood, irritable mood, or loss of interest in daily activities, as well as at least five additional symptoms such as insomnia, fatigue, guilt feelings, difficulty concentrating, and recurrent thoughts of suicide (APA, 1994). Dysthymia, a less severe depressive disorder, may be diagnosed in adolescents who do not meet the criteria for major depression. Dysthymia may be diagnosed in adolescents who report a depressed or irritable mood for at least one year and the presence of two or more of the aforementioned symptoms.

Another negative affect disorder that coexists with adolescent alcohol and substance abuse disorders is PTSD. The DSM-IV defines PTSD as the development of specific symptoms following exposure to a traumatic event such as death or serious injury to which the person responds with intense fears, helplessness, or horror (APA,

1994). The symptoms that generally follow, include re-experiencing the event through dreams, or experiencing intense distress when exposed to cues that recall an aspect of the event. Other symptoms include avoidance of people, conversation, places, thoughts, and activities associated with the event as well as diminished interest in activities and increased arousal indicated by sleep difficulties, irritability, and difficulty concentrating.

The high rates of major depression and PTSD among adolescents with alcohol and substance abuse problems indicate that is necessary to understand the relationship between these disorders and alcohol abuse (Clark & Miller, 1998). Histories of childhood physical and sexual abuse are common among adolescents with a negative affect disorder and alcohol or substance abuse problems (Deykin & Buka, 1997). Clark and Miller (1998) hypothesize that physical and sexual abuse may influence the development of a negative affect disorder, which may in turn lead to a substance use disorder. They feel that this occurs as a result of attempted self-medication. This occurs when the person, in an attempt to alleviate pain, uses alcohol or drugs. As with conduct disorder, alcohol abuse may both contribute to and result from negative affect disorders. In addition, negative affect disorder can lead to an appearance of conduct disorder symptoms once alcohol and substance abuse has started. This is why assessment can be considered an important part of treatment. In order to implement a treatment plan properly, two-tiered assessment is necessary. The first tier of the assessment must determine the extent and severity of the substance abuse. After this has taken place, the cause of the alcohol and substance abuse problem must be determined. At this stage, the underlying issues must be explored. It can be assumed that treatment for an adolescent whose problem emanated

from negative affect disorder will be different from treatment for an adolescent whose problem is conduct disorder related.

Treatment

In view of the substantial relationship between substance abuse and other mental disorders, it is important for a treatment plan to address many aspects of mental health. Some treatments that have been successful with individuals with substance abuse and conduct disorder focus on changing behavior. These strategies include family intervention contingency management programs with incentives for good behavior and social skills training (Buckstein, 1995). Other treatments involve medication, which can be used to treat the problems of impulsivity, anxiety, and aggression that are often present in adolescents with conduct disorder. The frequent comorbidity of conduct disorder with Attention Deficit Hyperactivity Disorder (ADHD) suggests that these adolescents may benefit from medications that are effective for ADHD. Stimulants such as methylphenidate (Ritalin)® or dextroamphetamine have shown positive results (Klein et al., 1997); however, the use of such drugs is controversial because they may be abused or sold illegally. There is a lack of data concerning the use of pharmacological treatment for adolescents with conduct disorder and, therefore, research is needed to determine if the use of medications for these diagnoses is warranted.

Clinicians with adolescent clients with substance and alcohol abuse disorders must also be aware of treatments for negative affect disorders. A number of treatment strategies address adolescent alcohol and substance abuse and common comorbid mental disorders. These treatments include family intervention and cognitive behavioral therapy. Family intervention can be used to help the family function as a cohesive unit. Many

times family cognitive behavioral therapy is needed to control the behavior and help the client understand it. This therapy combines behavior management with cognitive therapy. In effect, the client is not just stopping a behavior, but also learning what causes it and why it is maladaptive. Medication can also be helpful in treating negative affect disorders. However, the use of medications is questionable when there is a coexisting alcohol and substance abuse problem.

While all of the aforementioned treatments have some merits, it is important to develop an inclusive treatment plan that deals with all the variables of alcohol and substance treatment. This would have to be a treatment approach that can be implemented along with a coexistent diagnosis of conduct disorder or negative affect disorder. This is important for several reasons. Firstly, in any community or treatment center setting there is a likelihood of the presence of both negative affect and conduct disorder cases. In addition, as alcohol and substance abuse progress, the lines between the comorbid psychopathology may be blurred; therefore, an ideal treatment plan should be effective regardless of the specific coexisting psychopathology.

Such an intensive treatment strategy was developed by Hengeller and colleagues (1998). This treatment, called multi-systemic treatment (MST), has considerable support. MST is an intensive multidimensional approach combining family, peer, school, and community interventions with individual counseling. This is done in order to target multiple risk factors and problems. Treatment sessions can be provided in the home and at times that are convenient for family members, in order to facilitate attendance and family involvement (Hengeller et al., 1996). Family interventions are designed to foster effective parenting and family cohesion using strategies from varying theoretical bases.

In effect this means that the therapist is free to use different approaches in order to facilitate empowerment of the parents. Parental empowerment is an important part of any therapy session involving behavioral difficulties and is generally the building block of further treatment. Parents are then directed to increase monitoring of their child's relationship with peers as well as working towards improvement of their child's school performance. Individual sessions with the adolescent target skill training and behavior change (Santos et al., 1995).

MST has been evaluated in controlled trials and found to be effective in reducing antisocial behaviors, substance-related arrest, and substance use (Hengeller & Colleagues, 1998). It is also designed to be effective in treating substance abuse and negative affect disorders. For example, an adolescent may need group therapy to address difficulty with problem solving, anger control, and relapse prevention. The family may benefit from therapy designed to address issues of communication, parental control, and supervision. Medications may also be needed to address problems such as PTSD and major depression. MST is designed as global approach to treatment.

A large part of all the aforementioned treatment plans addressed by MST involves modeling. Modeling is part of many drug treatment programs and is included in many therapy manuals designed for hands-on treatment of addicts (Steinman, 1996). Modeling is also used in addressing clinical problems that may arise during treatment (Steinman, 1997). Although modeling is a part of most drug treatment plans, it has not been shown that it is the best way to effect cognitive change.

While research has shown that a systemic approach can be successful, the educational needs of the clients are not fully or necessarily addressed. A cognitive

approach recognizes the process of therapy as a learning process, as any procedure that seeks to change behavior can be viewed as a learning process. It can be theorized that a process in which behavior is changed through learning will have a long lasting effect because the shared learning may serve to internalize the therapy process. This in turn, may help the client to generalize and transfer the information presented.

The Mediated Learning Experience Model

Haywood (1992) presents a form of cognitive educational therapy that may serve to enhance the modeling aspect of therapy. This form of therapy focuses on metacognition and is largely based on the work of Feuerstein and colleagues (1980). Feuerstein advocates a form of education based on interactions characterized as mediated learning experience (MLE). MLE promotes higher order thinking and internal control by helping the client make connections between events and increase reflective thinking. Another benefit of this approach is that it is structured. The lessons to be taught are preselected and developmentally appropriate.

Haywood (1992) pointed out that in order for a learning experience to be considered mediational several criteria must be met. The first criterion is intentionality. This means that the goal must be to produce change in the client/ student. The second criterion is transcendence, which means that the immediate experience must generalize to other aspects of living, thinking, learning or understanding. This concept corresponds well with the drug treatment concept of relapse prevention, in that it helps to generalize cognitive concepts to new situations as they arise. Third, communication of meaning and purpose is important in that it helps clients understand the meaning of their activities. Fourth, it is also important that the counselor mediates a feeling of competence so that the

clients feel they have the control and ability to change. This is accomplished by acknowledging correct and incorrect responses and behaviors. On a metacognitive level it is important to help the clients understand what led to their correct response and feeling of validation. Impulsivity must also be controlled both because it impairs learning and because it is part of the original problem behavior. Finally, an important criterion for mediated learning is that the learning be a shared experience.

Although Haywood's program was not designed specifically for addictive behavior, it appears to have the potential to be useful as an enhancement of an MST program. This is due to the fact that his program takes into account the limitations of cognitive therapy and acknowledges the roles of volition and conation (Haywood, 1992). This application of mediated learning may serve to enhance the modeling process, which is already part of most treatment programs. Haywood (1992) states that the ultimate goal is to enhance the development of persons to think of themselves as cognitively competent, and as able to use their own abilities to solve problems in their everyday lives. This goal is consistent with the MST goal of treating every aspect of the client's life, and may therefore be used as an enhancement of the modeling aspect of treatment. However, before incorporating a new program into an existing approach, it is necessary to elicit the cooperation of the individuals who will be asked to implement the changes. With this in mind a first step would be to sample the attitudes of the professionals who would be involved in treatment regarding potential implementation of the program. Therefore, this study surveys the attitudes of professionals already engaged in MST service delivery regarding their openness to considering the addition of MLE in

their treatment plans. This study also compares the attitudes of social workers with psychologists to explore possible differences.

Method

Participants

Fifteen school psychologists and fifteen social workers participated in this study. All respondents had Masters degrees in their field. Specific information regarding gender, ethnicity, experience, and degree of familiarity with MST and MLE was unavailable to the author.

Procedures

The participants were obtained through a networking process. A school psychologist was asked to distribute the survey at a district meeting she attended. This allowed for all school psychology respondents to be unaware of who was conducting the study. The social worker respondents were obtained by giving five copies each to social workers who worked part time at the same agency as the author. They were asked to give copies to social workers employed by other prevention programs.

The questionnaire

The questions were developed by the author to assess several areas. The first question assessed the general feeling towards MST. The remaining questions were developed in order to assess the reactions to several areas of therapy. The areas included the actual therapy process as it pertained to both conduct and negative affect disorders. Also included were questions dealing with parents and teachers as part of the therapy process as well as family therapy.

The items were put on a Likert scale, ranging from 0-6 rather than 0-5 to avoid the tendency to answer three on 0-5 scales. Since the interest of this study is in responses to each item, the average rating for each item across groups was used as the score for analysis. The survey appears in appendix A.

Results

Data were collected to respond to the two questions of this study: What is the general attitude of the participants toward including MLE as an addition to the currently used MST treatment model, and, to what extent did the attitudes of social workers differ from attitudes of psychologists. The average score on each item for the total group appears in table 1.

Table 1 Total Group Means Responses to Questionnaire Items

	X
1.	5.56
2.	4.96
3.	4.76
4.	4.63
5.	4.73
6.	4.83
7.	4.86
8.	4.66
9.	4.80
10.	4.30
11.	5.40

The average score on each item for Social Workers and School Psychologists appears in Table 2.

Table 2

Average rating on each question (N=30)

	School Psychologists		Social Workers	
	X	S.D.	X	S.D.
1.	5.46	.74	5.66	.72
2.	5.00	.84	4.93	.88
3.	5.00	.84	4.53	1.06
4.	4.93	.79	4.33	.81
5.	4.66	1.04	4.66	.97
6.	4.93	1.22	4.73	1.09
7.	4.93	.88	4.80	.86
8.	4.93	1.03	4.40	.91
9.	4.93	.70	4.66	.97
10.	4.06	.83	4.53	.83
11.	5.46	.91	5.33	.81

Table 1 shows that both groups responded favorably to using MLE as an enhancement to MST. Table 2 shows that there is no significant difference in the responses of the two groups. Since the scores were so similar to each item, it was not necessary to conduct a statistical analysis.

The first question in this study attempted to establish a base point concerning how participants felt about MST as a program. This is necessary because the study assumes that MLE would be used to enhance rather than replace MST. Both groups responded favorably to MST as a program with responses at the high range of the scale. There was no significant difference in the responses of the two groups.

The second, third and fourth questions dealt with using MLE as an educational tool for students, schools and families. As per the hypothesis, both groups responded favorably with the responses at the low end of the highest ranking or the high end of the middle ranking. The differences between groups were not statistically significant.

Questions five through ten dealt with the clinical issues of comorbid pathologies and recidivism. Both groups responded at the higher end of the middle grouping. There was no significant difference between the two groups.

Question eleven dealt with using MLE to teach communication skills in family therapy. Both groups rated MLE at the lower end of the highest group. There were no significant differences between the two groups.

Discussion

This study investigated the attitudes of Psychologists and social workers currently involved in MST service delivery to substance abusing adolescents regarding the addition of MLE to their treatment plans. The survey documents a generally favorable attitude toward considering this inclusion, as well as no difference between the attitudes of the two groups. This study had several limitations. Firstly, the size of the groups limited the validity of the results. The networking process used to obtain respondents also damaged validity through lack of randomization. Another limitation is that the knowledge base of

the respondents regarding MLE was limited to the enclosed survey while MST was a system they already used. In order to properly assess this program they would need a better foundation regarding the procedures of MLE.

The results are encouraging regarding the positive and open attitudes of these professionals regarding the addition of MLE to their treatment plans. Further training in this approach would be necessary as well as more specific elaboration of MLE into sample treatment plans. Future studies would evaluate the contribution of MLE to the improvement in treatment outcomes of the substance-abusing adolescents. This study demonstrates a useful role for School Psychologists regarding their ability to contribute to data – based decision making. It also shows how ideas for changes in clinical practices can be made with sensitivity toward those who would be expected to implement the change. Such data provide a foundation for further monitoring of attitudes toward changes as they are implanted.

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Appendix A: The questionnaire

Please read the following treatment descriptions and answer the questions that follow.

Multi Systems Treatment

Adolescent substance and alcohol abuse is commonly thought to share comorbidity with both conduct disorder and negative affect disorders such as posttraumatic stress disorder and depression. Research has shown that multi-systems treatment ("MST") can be an effective approach. This theory involves treating the patient in the many different environments that exist. This includes one on one therapy, family therapy and therapy that incorporates the community and educational settings in which the client lives. Modeling is a psychological tool that is implicit in systems based treatment. Modeling is used in treating the client as well as the family. It can also be used in educating school officials and community leaders in the early detection and treatment of substance abuse and the pathologies that share a dual diagnosis with it.

Mediated Learning Experience

Mediated Learning Experience ("MLE") is an alternative mode of teaching that may be used as an enhancement of modeling. Ruben Feuerstein developed MLE, which is based on the shared interaction between an adult and a child, which is used to produce a more generalized understanding. In MLE the teacher/ therapist teaches client/student the concepts and behaviors to be learned. The method is to have the client/student verbalize the rules, strategies and concepts that the mediator provides. The learning is internalized by questioning both correct and incorrect responses, and asking the clients to provide their own examples from their everyday lives. The concepts are generalized by

connecting them to events in the client's everyday life. MLE differs from modeling in that the mediator leads the client in developing cognition using participation in place of imitation.

Discipline: _____

Based on the above descriptions, using the scale of 0-6, please indicate through the following questions to what extent you feel MLE has the potential to enhance the effectiveness of modeling as a component of and treatment for substance abuse.

6-5	4-3	2-0
Extremely	Moderately	Minimally – Not at all

1. To what extent do you feel MST in an effective form of treatment for substance abuse?

2. To what extent can MLE aid in helping clients develop cognitive strategies to aid in their treatment?

3. To what extent can MLE help facilitate the clients understanding of the factors that led to substance abuse?

4. To what extent can MLE aid in developing client self regulation?

5. To what extent can MLE help in teaching parents and educators pro-active measures to prevent substance abuse?

6. To what extent can MLE help parents and educators see the signs of substance abuse to allow early detection?

7. To what extent can MLE aid in treating the co-morbid pathology of conduct disorder?

8. To what extent can MLE aid in treating the co-morbid pathology of negative affect disorder?

9. To what extent can MLE aid in enhancing parent awareness of co-morbid pathology?

10. To what extent can MLE aid in teaching clients the signs that lead to recidivism?

11. To what extent can MLE aid in teaching communication skills in family therapy?